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ABSTRACT

This paper contains an outline of a workshop designed for the disaster mental health worker. The goal of the workshop is to describe how disaster services are different from other mental health services and to provide suggestions on how to make these services more effective. The types of disasters, the anatomy of a disaster, and time phases of a disaster are all explained. The barriers to overcome in disaster relief for the helper and the survivor are also highlighted. One particular barrier that needs consideration is the cultural bias that may exist in a counseling relationship. Suggestions are provided for types of individual help that can be given in a disaster. These include food, clothing, housing and funding, medical care, emergency funds, legal assistance, disaster unemployment, and property cleanup. Children's disaster reactions that need to be addressed include academic and behavioral regression, behavioral deficits or excesses, emotional reactions, and motivational changes. (Contains 13 references.) (JDM)

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OVERCOMING DISASTER BARRIERS TO SERVICE ALL CHILDREN

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INTRODUCTION

❖ **Tramonte's Disaster Mental Health (DMH) Red Cross Experiences**

Oklahoma Tornadoes – assigned to a service center

New Mexico Wildfires – assigned to emergency outreach

Worcester, MA Fire – assigned various duties

Mass/RI EgyptAir Crash – assigned to the family center

Wakefield, MA Workplace Shooting – assigned to a center to help employees

Massachusetts Floods – assigned to outreach and made a condolence visit

Newton, MA Bus Accident - assigned to the memorial service for deceased Students

Texas Tropical Storm – assigned to a service center

New York World Trade Center – assigned to outreach near Ground Zero

Several Local and State Fires – assigned to help relatives of deceased

❖ **Goals of Current Workshop**

Become Disaster Volunteer – helping is rewarding in and of itself

Learn About Disaster Mental Health (DMH) Uniqueness – DMH is somewhat different from traditional mental health services

Overcome Disaster Barriers – remove obstacles to help survivors/victims and relatives, friends, neighbors, etc.

Avoid Experiencing Helper's Compassionate Fatigue – take care of yourself

Learn About Self – know what you can and cannot do

DISASTERS

❖ **Definition of Disaster** – FEMA's Definition

Natural Catastrophe – can be natural, technological, or criminal

Damage of Sufficient Severity – tremendous damage

Federal. Government Supplementary Assistance – outside help is needed

Alleviates Damage, Loss, Hardship, Suffering – helps those is need

- **Types of Disasters** – National Center for PTSD (2001)

  Natural (earthquakes, floods, hurricanes, tornadoes, wildfires)

  Technological (chemical, explosions, fires, toxic spills, transport accidents)

  Criminal (arson, gang violence, riots, mass killings, terrorist acts)

- **Anatomy of a Crisis (Disaster)** - Parad et al (1975)

  A precipitating event (stressor) (Any natural, technological, or criminal event that causes widespread trauma)

  Perception of the event (Is the event viewed as an opportunity or a danger?)

  Response to the event (this is a period of trial-and-error efforts at regaining some semblance of order that can facilitate a return to pre-crisis conditions. It is a time of emotional difficulty and often pain).

  Resolution of the problem(s) (This is when adaptive coping or problem-solving efforts have fallen into place and serious progress toward recovery is becoming a reality).

- **Time Phases of a Disaster** – Kafrissen, Heffron, and Zusman (1975)

  Alarm (or warning phase) (present in disasters with slow, more predictable onset and a time when stress levels are rising). This is not found in unexpected disasters such as the WTC terrorist attack.

  Threat (period of imminent danger and assessment of degree to which real threat exists)

  Impact (time during which the event occurs, normally a time of tension but not panic).

  Inventory (people get out and survey the damage and while it may seem to be a highly stressful period of mass confusion, recovery begins).

  Rescue (some will show evidence of the disaster syndrome (shock, suggestibility, and recovery-telling one's story) as efforts to assist the victims are undertaken)

Remedy (morale is high for many, but the stress is taking its toll on others during what is possibly the longest phase, and the time when large-scale relief efforts take place).

Restoration (recovery) (this point is the "light at the end of the tunnel," and the point for which everyone has been waiting).

❖ **Four Phases of a Disaster** - American Red Cross (1994)

Heroic (prior to and at the time of the disaster). Individuals work together to save each other and property. Search and rescue, assessment of damage, information gathering, mobilization of resources

Honeymoon (one week to three to six months after the disaster). Because of Promises of help, survivors feel optimistic about rebuilding their lives. Super volunteers emerge, community cleanup/relief efforts.

Disillusionment (two months to one to two years later). Frustrated by bureaucracy's recovery delays, survivors turn to themselves to rebuild their lives. "Second disaster:" assistance leaves, long hours at work, paperwork/documentation, lawsuits filed, rebuilding/restoring

Reconstruction (may last for several years). Individuals and communities work together to rebuild and reestablish normal functioning. Long waits for additional assistance; federal program approval, insurance payoffs, lawsuit resolutions.

❖ **Disaster Mental Health Differences from Non-Disaster Mental Health** - (Abstracted from publications from the National Institute of Mental Health (NIMH) now known as the Center for Mental Health Services (CMHS).

All are affected (survivors, witnesses, recovery and relief workers, families, relatives, friends, and co-workers)

Individual and collective trauma (**individual trauma**– the stress and grief reactions which individual survivors experience and **collective trauma**– which can sever the social ties of survivors with each other and with the locale)

Survivors pull together (especially during the "heroic" and "honeymoon' phases of the disaster but when reality of the loss becomes more real, grief reactions intensify and impair functioning)

Normal Survivor Reactions (survivor reactions need to be normalized for most who are reacting to an abnormal situation and those survivors whose grief responses are pathological, a referral may be necessary)

Reactions to problems of living (Many of the emotional reactions of disaster survivors stem from problems of living brought about by the disaster such as: locating missing loved ones: finding temporary housing, clothing and food; getting medical care; replacement of eyeglasses or medication; and applying for financial assistance).

Relief: the second disaster (Disaster relief procedures have been called, "the Second Disaster." This involves the process of obtaining temporary housing, replacing belongings, getting permits to rebuild, applying for government assistance, seeking insurance reimbursement, and acquiring help from private or voluntary agencies. They are often fraught with rules, red tape, hassles, delays, and disappointment).

Survivors may avoid mental health services (Many survivors do not see themselves as needing mental health services that some equate to being "crazy." They are more interested in reducing the pragmatic pressures of putting the concrete aspects of their lives back together).

Survivors may reject all disaster assistance (Survivors may not only reject DMH assistance but any disaster help at all).

DMH more practical than psychological (DMH workers respond first to the practical and concrete basic needs of survivors)

DMH tailored to the community (DMH services must be uniquely tailored to the communities they serve). Workers must be sensitive to cultural, ethnic, racial, and socioeconomic diversity).

Outreach & avoidance of labeling (DMH staff need to set aside traditional office-Based methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in a disaster).

Helpers and :Compassionate Presence" (Survivors respond to active interest and concern known as "compassionate presence")

Interventions related to disaster phase (DMH interventions must be appropriate to the fourfold phase of disaster: heroic, honeymoon, disillusionment, reconstruction)

Support systems are very crucial – (Support systems are crucial to recovery. The most important support group for individuals is the family. Workers should attempt to keep the family together in shelters and temporary housing, for example)

Reactions to problems of living (Many of the emotional reactions of disaster survivors stem from problems of living brought about by the disaster such as: locating missing loved ones: finding temporary housing, clothing and food; getting medical care.

❖ **Goals of Disaster Mental Health** – National Center for PTSD (2001)

Protect: Help preserve survivors' and workers' safety, privacy, health, and self-esteem.

Direct: Get people where they belong, help them to organize, prioritize, and plan.

Connect: Help people communicate supportively with family, peers, and resources.

Detect: Screen, triage, and provide crisis care to persons at-risk for severe problems.

Select: Refer people to health, spiritual, mental health, or social financial services.

Validate: Use formal and informal educational opportunities to affirm the normalcy and value of each person's reactions, concerns, ways of coping, and goals for the future

DISASTER BARRIERS

❖ **Overcoming Disaster Barriers**

All – Some – No Other - Every Survivor/Victim Is Like All, Some, and No Other Survivor/Victim

❖ **Helper's Disaster Barriers**

Personal History –the helper's premorbid personality and experiences

Cognitive Map, including Biases – attitudes toward self, the world, and the relationship between self and the world; this includes being aware of how culture and ethnocentricism can influence the way one views the world.

Previous and Recent Losses – similar or unrelated past disaster experiences as well as other past, present, and possible future losses of which one is aware

Current Disaster Losses – away from home, loved ones, one's routine, etc.

Unresolved Personal Issues – past experiences that have not been resolved sufficiently

Attitude/Feelings Toward Disaster – anxieties that may be interfering with helping others

Fears – concerns about something happening while helping others and/or while being at the disaster site

Self-Doubt – Doubt about one's knowledge and helping skills

Compassionate Fatigue – burnout can occur if the helper is overworked and deeply engrossed in helping numerous survivors

❖ **Survivors' Disaster Barriers**

Survival and Basic Needs –Like Maslow's Hierarchy of Needs, the basic needs are primary and include physiological and safety needs.

Previous History - previous losses especially related to the current disaster – ex. experiencing a fire

Personal History – previous losses related to or not to the current disaster; and the health of the premorbid personality

Cognitive Map, including Biases – attitudes toward self, the world, and the relationship between oneself and the world.

Previous and Recent Losses – whether similar or not to the current disaster; also, the awareness of possible future losses can influence one's reactions

Current Disaster Losses -loss of control over their own life, loss of faith in their God and/or in other people, loss of a sense of fairness or justice, loss of personally significant property, loss of loved ones, loss of a sense of immortality or invulnerability, loss of a perceived future

Unresolved Personal Issues – past conflicts that have not been resolved and can affect one's coping skills to the disaster

Attitude/Feelings Toward Disaster – worried about another similar disaster occurring

Fears – several fears develop as a result of the chaotic, unstructured, and disaster situation

Self-Doubt – how one feels about self influences one's coping reactions

Loss of Support System – a support system is needed to be there for the survivor

Separation From Parents – The family is the most important support system for a child.

❖ **Additional Survivors' Disaster Barriers -The Disasters Themselves**
- National Center for PTSD

Exposure to Traumatic Events

Exposure to Life Threatening Danger or Physical Harm (especially to children)

Extended Exposure to Danger and Loss

Exposure to Gruesome Death, Bodily Injury, or Bodies

Exposure to Extreme Environmental or Human Violence or Destruction

Emotional/Physical Strain

Loss of Home, Valued Possessions, Neighborhood, School, Community, & People

Exposure to Toxic Contamination (e.g., gas or fumes, chemicals, radioactivity)

Intense Emotional Demands (e.g., rescue personnel; caregivers)

Extreme Fatigue, Weather Exposure, Hunger, Sleep Deprivation

❖ **Other Disaster Barriers**

Communication - FEMA reported five obstacles to effective worker and survivor communication: (1) language; (2) nonverbal communication; (3) preconceptions and stereotypes; (4) the tendency to judge others; and (5) high anxiety.

Misinformation and Rumors – Because some communications may be disengaged, misinformation may be present and rumors spread. Consequently, compile factual information and share it truthfully with survivors.

Changes in Routine – One's routines are shattered. Help the child cope by bringing in some stability to the child's life. Family, school, community, and friends are dislocated.

Relocation – survivors may be forced to live elsewhere in a different neighborhood.

Multiple Victims/Destruction - The number and severity of injuries – Multiple victims can be more traumatic for the survivors who witness numerous people die.

Diversity – awareness and sensitivity to diversity: gender, age, physical appearance, ethnic or cultural background, economic status, religious orientation, educational background, physical health and ability, and sexual orientation.

Culture and Ethnocentrism–Know the culture and the community you are helping in. Respond in sensitive cultural ways. Avoid ethnocentrism, believing in the superiority of your own ethnic group and believing in the viewpoint that your cultural-lens is the only way of perceiving reality.

CULTURE

❖ **Ten Commonly Reported Cultural Barriers** – Quoted From Pedersen (1987)

1. Normal Behavior is Universal – This is the implicit assumption that the definition of normal is more or less universal across social, cultural, and economic or political backgrounds (p. 17).

2. Emphasis on Individualism – The individual is the basic building block of society. Many counselors in the United States presume that counseling is primarily directed toward the development of individuals rather than units of individuals or groups such as the family, organizations, or society(p. 18).

3. Fragmentation by Academic Disciplines – Problems are defined from a framework limited by academic discipline boundaries. There is a tendency to separate the identity of counselor from that of psychologist, sociologist, anthropologist, theologian, or medical doctor (p. 19).

4. Dependence on Abstract Words – Western culture depends on abstract words and counselors in this setting assume that others will understand these abstractions in the same way as they intend. Yet, there are high-and low-context cultures (p. 19).

5. Overemphasis on Independence – As part of the Western emphasis on individualism, there is a presumption that an individual should not be dependent on others; nor should the individual allow others to be dependent on them. Yet, there are many cultures in which dependencies are described as not only healthy but absolutely necessary (p. 20)

6. Neglect of Client's Support Systems – Counselors need to endorse the potential effectiveness of family and peer support to a client. In many cultures, the notion of formal counseling is less preferred than nonformal or informal alternatives available to a client (p. 21).

7. Dependence on Linear Thinking – This is the assumption that everyone depends on linear thinking—wherein each cause has an effect and each effect is tied to a cause—to understand the world around them. Yet, in a nonWestern cultural context the cause and the effect are seen as two aspects of the same undifferentiated reality (p. 21).

8. Focus on Changing Individual, Not System – This is the assumption that counselors need to change individuals to fit the system and not change the system to fit the individual (p. 22).

9. Neglect of History – This relates to the relevance of history for a proper understanding of contemporary events. Counselors are more likely to focus on the immediate events that created a crisis and neglect the client's history (p. 23).

10. Dangers of Cultural Encapsulation – Counselors believe that they already know all of their assumptions. They need to recognize the dangers of a closed, biased, and culturally encapsulated system that promotes domination by an elitist group, whatever its origin or special point of view (p. 23).

TYPES OF INDIVIDUAL HELP POSSIBLE IN DISASTERS AND CHILDREN'S REACTIONS

- **Types of Individual Help Possible in Disasters** - Faberow & Gordon (1981)
  - **Food**
  - **Clothing**
  - **Housing or Home Furnishings**
  - **Medical Care**
  - **Emergency Funds**
  - **Legal Assistance**
  - **Disaster Unemployment Assistance**
  - **Income Tax Assistance**
  - **Property Cleanup**
  - **Home Repairs or Reconstruction**

- **Business Repair or Reconstruction**
- **Business Repair of Maintenance**
- **Farm Repair or Maintenance**
- **Moving Assistance**
- **Official Information**

❖ **Children's Disaster Reactions**

Reactions are somewhat dependent upon the child's chronological and developmental stages.

Academic and behavioral regressions – singing/humming childhood songs; assuming a fetal position; calling a police officer or other authority figure "daddy" or "mommy;" feeling "little' and/or "weak;" wanting "mommy" or "daddy" to come take care of them; bedwetting; thumbsucking.

Behavioral changes – Young people sometimes express their emotions through "acting-out" behaviors (temper outbursts, being argumentative). Children may behave differently than previously before the trauma. They may now cling more often to parents. They may now exhibit changes is eating, sleeping, and going to school.

Behavioral excesses – eats a lot more; sleeps a lot more; is hyperactive and hypervigilant; repetitive play; compulsive; repetitive mannerisms (such as repeatedly zooming a toy car into a doll)

Behavioral deficits – eats as lot less; sleeps a lot less; is lethargic; and not vigilant to surroundings

Behavioral inappropriateness – behaves inappropriately according to chronological and developmental age expectations for reacting to a trauma.

Cognitive – inability to concentrate; unable to remember things; disbelief; confusion; preoccupation; hallucinations (flashbacks)

Emotional – Cries a lot; lack of emotional display; anxiety; fears of the future about dying, of a loved one dying; fears of being left alone; worries; guilt; sadness; anger; anxiety; fatigue; helplessness; yearning; hopelessness; grief

Motivational – concentrates on basic needs (physiological, security, lodging,

looking for loved ones, etc.)

Physiological-nightmares; night terrors; & sleep disturbances. Frozen fright; "fight or flight" reaction exhaustion; physical symptoms; breathlessness/shortness of breath; lack of energy; dry mouth; weakness in muscles; tightness in chest and/or throat; oversensitivity to noise

Behavioral – sleep disturbances; appetite disturbances; social withdrawal; avoidance of reminders of the incident; restless overactivity; treasuring objects

Spiritual – trying to understand why bad things happened to good people and how God could allow such tragedy.

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